

**Emerald Coast Internal Medicine and Geriatrics**

**Personal Information:**

Do you have any food ,latex,or drug allergies? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Drug Allergies:**

Name: \_\_\_\_\_ reaction \_\_\_\_\_

Name: \_\_\_\_\_ reaction \_\_\_\_\_

Name: \_\_\_\_\_ reaction \_\_\_\_\_

Name: \_\_\_\_\_ reaction \_\_\_\_\_

Name: \_\_\_\_\_ reaction \_\_\_\_\_

**Environmental :**

Name: \_\_\_\_\_ reaction \_\_\_\_\_

Name: \_\_\_\_\_ reaction \_\_\_\_\_

Name: \_\_\_\_\_ reaction \_\_\_\_\_

Name: \_\_\_\_\_ reaction \_\_\_\_\_

Do you use Tobacco \_\_\_\_\_ Pack s per day \_\_\_\_\_ How Long \_\_\_\_\_

If you ever smoke and stop : How Long ago \_\_\_\_\_

Other drug usage: \_\_\_\_\_ Yes \_\_\_\_\_ No

Caffeine Use : Daily , Frequently , Moderately , Occasionally , Never

Difficulty Sleeping : Frequently , Occasionally

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date